

**Supplemental Security Income—Disabled Children: Time for Fundamental Change**

**Testimony Prepared for:  
Ways and Means Subcommittee on Human Resources  
Rayburn House Office Building, Room B-318  
Washington, DC  
October 27, 2011**

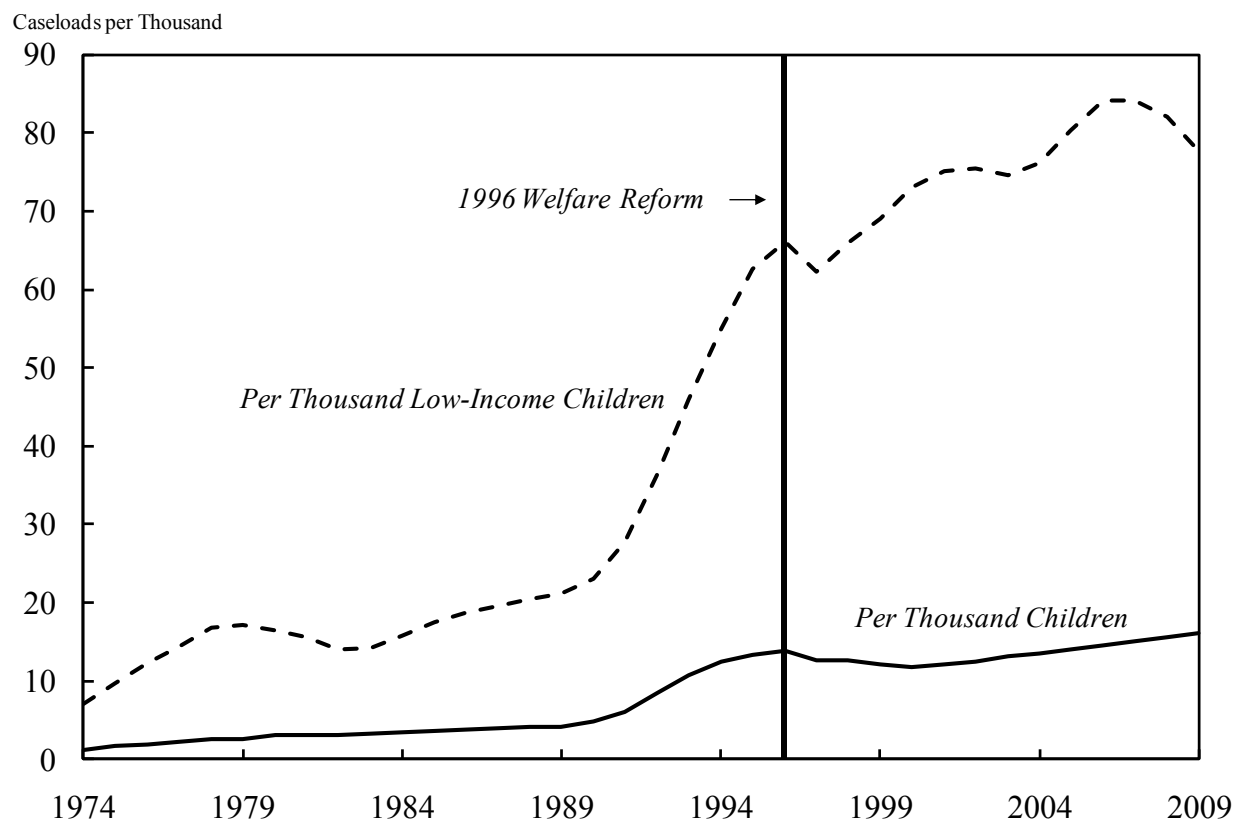
Professor Richard V. Burkhauser  
Department of Policy Analysis and Management  
Cornell University

**This is a condensed version of Chapters 6 and 7 from: Richard V. Burkhauser and Mary C. Daly. 2011. *The Declining Work and Welfare of People with Disabilities: What Went Wrong and a Policy for Change*, AEI Press: Washington DC**

Since 1974 the Supplemental Security Income-disabled children program has provided benefits to poor families with age-eligible disabled children. Based on our reading of the evidence however this program has increasingly become a more general welfare program that in large part targets a population of able-bodied single mothers that overlaps with the TANF (Temporary Assistance for Needy Families) population. And, whose children have medical conditions that are increasingly difficult to objectively measure and are coming onto the program via increasingly subjective evaluations by Social Security Administration gatekeepers.

This has resulted in substantial program growth both in terms of caseloads and expenditures. The SSI-disabled children program serves only children living in low-income families, so to get an accurate picture of its growth it is important to adjust these measures relative to the potentially eligible population. Two such adjusted measures, an age-based metric and an income-based metric, are shown in figure 1.

**Figure 1.** SSI-Disabled Children Caseloads per Thousand Children and per Thousand Low-Income Children over Time



Source: Social Security Administration 2009a; and U.S. Census Bureau 2010.

This figure reports the levels and trends in the number of children receiving SSI-disabled children benefits per thousand children under eighteen (age eligible), and the number of

children receiving SSI-disabled children benefits per families in poverty (income eligible). These measures provide rough estimates of the changing importance over time of the SSI-disabled children programs to the general population of low-income families with at least one child. The SSI-disabled children caseload as a percentage of the age-eligible population has grown over time, with especially large increases since 1989. Considering the caseloads relative to the population meeting both the age- and income-eligibility guidelines, the growth in caseloads is even more rapid. Program growth was rapid in the 1970s at the program's beginning, and it was followed by relatively slow growth through most of the 1980s. In 1990, caseloads jumped following the Supreme Court decision that expanded eligibility, and continued to rise until 1996. Caseloads per thousand children fell for one year in 1996 before trending upward again. By 2006, over eighty children per thousand age- and income-eligible children were receiving SSI-disabled children benefits. The rate has fallen somewhat in the wake of the recession, but that owes to the outsized increase in the number of low-income children associated with the economy's downturn.

### **Why Have SSI-disabled Children Caseloads Risen?**

There are several possible explanations for the increase in SSI-disabled children program growth that can be broadly classified into two groups: (1) those that are exogenous to the program—changes in the underlying severity of disability among children and (2) those that are endogenous to the program—Welfare Reform, the size of SSI benefits relative to AFDC/TANF benefits, specific changes in SSI-disabled children program rules and their interpretation and implementation over time. Economists have examined each of these possible explanations and generally concluded that although each played some role, factors that are endogenous to the program had the largest impact on both the growth and fluctuations highlighted in figure 1.

**Health.** Defining and measuring disability in children is difficult and complicated. That said the limited information on trends in child health and functional limitation point to little change over time. We report data on self-assessed health, specifically the percentage of children under age eighteen assessed by parents to be in poor or fair health. Although there is some fluctuation over time, we find no notable upward trend in the prevalence of poor or fair health over time. We also report the percentage of children ages five to seventeen with an activity limitation by poverty status. Again, the key finding is that there has been little change over time in functional limitations among any of these populations, including those who may be income-eligible. While these data are limited, they provide little indication that changes in child health can explain the enormous variation and growth in the SSI-disabled children rolls relative to the age- and income-eligible population observed in figure 1.

**Welfare Reform and the Size of SSI-Disabled Children Benefits Relative to AFDC/TANF benefits.** The SSI-disabled children program provides cash benefits to families with low income and a disabled child. But the program might more accurately be called the *Aid to Families with Disabled Children* since it does not directly provide services to children with disabilities, nor tie benefits to the purchase of services for the

disabled child. Rather it is much closer in design to a general welfare program in which benefits are income tested but also require the child of able-bodied parents to have a disability.

Hence the disabled child's interests are represented by the parents and, to a lesser extent, by the state. While this is reasonable, it means that the decision to apply for SSI-disabled children benefits can be based as much on the family's economic circumstances as on the child's disability and specific needs for care. Indeed, Rupp and Ressler (2009) find that the probability that a parent with a disabled child is working is driven by variables other than the severity of the child's impairment. Thus for those who are working at the time of the child's health shock, a parent or parents will be forced to decide whether to leave or reduce employment to care for the child. For the vast majority of Americans with long work histories, stable jobs, health insurance, and family income well above the minimum income protection of the SSI-disabled children program, it is highly unlikely that they will turn to this program for assistance.

For the minority of Americans with intermittent work histories, low-paying or unstable jobs, no health insurance, and family incomes near the SSI minimum guarantee, however, the benefits offered first by temporary welfare (AFDC/TANF) and eventually by the SSI-disabled children program are a possible alternative path given a child's unexpected health shock. In such cases, the child's impairment will certainly affect this decision, but so will the likelihood that the child will be eligible for SSI-disabled children program benefits and their future earnings and private access to health care. As Hemmeter, Kauff, and Wittenburg (2009) and Loprest and Wittenburg (2007) show, however, such children are much more likely to live with a single parent, and less than half of those single parents are employed. Thus, the majority of the families of SSI-disabled children benefits likely do not have a working member at the onset of the child's impairment. For a parent who is not working at the time a child experiences a health shock, decisions need to be made that will be affected by the child's health and likelihood of being found eligible for SSI-disabled children benefits. In addition, the family must determine whether there is a financial gain to qualifying for SSI over staying on the more general welfare program.

Wiseman (2010) estimated the relative financial gain for the average single-mother family on AFDC in 1996 if a mother were able to qualify her child for the SSI-disabled children program. In such a case, she would have nearly doubled her cash transfers. The gain was highest in states like Texas, where AFDC benefits were relatively low compared to SSI-disabled children benefits, but gains were still fairly large in states like California and New York, which had higher AFDC benefits but also offered state supplements to the federal SSI-disabled children payment. After welfare reform, the average gains were even larger. This understates the long-term gains to such single mothers because, under TANF, the mother is guaranteed only five years of benefits and is under other pressures to work. Under the SSI-disabled children program, benefits continue until the child turns eighteen, and the parent is not expected to work.

Evidence suggests that a large fraction of the children enrolling in the SSI-disabled children program in the 1990s previously participated in the AFDC program. Empirical

research examining the degree to which these relative gains produced this shift from AFDC/TANF to the SSI-disabled children program has found it to be significant (Garrett and Glied 2000; Kubik 1999). While it is difficult to identify the effect of this type of incentive, one paper (Kubik 1999) finds that reported disabilities by newly awarded SSI-disabled children—particularly mental impairments, which are the most difficult to objectively evaluate—were higher in states with lower AFDC benefits, where the relative gains from movement onto the SSI-disabled children program were higher.

States will also make decisions that influence whether a family that is either applying for state welfare benefits or already on them chooses to apply for SSI-disabled children benefits. Like the parent, the state will consider the child's health and the likelihood the child will be accepted into the program. The state will also consider whether the parent is a good candidate for employment. In the case of single mothers, it is in the interest of the state not only to encourage their AFDC/TANF population to apply for SSI benefits, but also to provide resources for them to do so. States will have an incentive to move their TANF families to the SSI-disabled children program in order to shift the responsibility of providing cash transfers for those adults to the federal government and reduce any cost the state would absorb in trying to encourage employment. While AFDC/TANF single mothers who are able-bodied are not candidates for the SSI-disabled adults program, their income maintenance would be guaranteed by the federal government if their child were eligible for the SSI-disabled children program.

Although the SSI-disabled children program was intended as an income-support program for families headed by parents who were unable to work because of their child's disability, it appears to have grown into an income maintenance program for low-income families with a qualifying child. This has altered the incentives for these families and the states in ways that likely affect outcomes including caseloads, costs, and ultimately the long-run economic status of the child. At each point in the process that leads parents to apply for SSI-disabled children benefits, decisions have to be made by both parents and the states that provide services to these families before they move further along the path to long-term benefits. The eligibility rules facing SSI-disabled children and how the system is financed influences the behavior of parents of disabled children and the states in which they live in their response to a child's health shock.

**Changing Program Rules.** When the SSI-disabled children program was originally considered, Congress recognized the potential difficulties of applying the standard SSA disability definition to children. Thus, under the original legislation, Congress wrote that a child should be considered disabled if “he suffers from any medically determinable physical or mental impairment of comparable severity” to a disabling impairment in an adult. Between 1974 and 1989, the child disability determination process did not include a functional assessment or account for the equivalent of adult vocational factors and the program experienced only modest growth.

This changed in 1990, when the U.S. Supreme Court decided the case of *Sullivan v. Zebley*. The Court ruled that to meet the standard of equal treatment, a functional limitation component parallel to that of adults must be included in the initial disability

determination process for children. In response, the Social Security Administration added two new bases for finding children eligible for benefits: (1) functional equivalence, which was set at the medical-listing level of the disability determination process; and (2) an individualized functional assessment (IFA), which was designed to parallel the vocational assessment provided for adults. By allowing applicants who did not meet the medical listing to be found disabled if their impairments were severe enough to limit their ability to engage in age-appropriate activities, such as attending school, the IFA lowered the level of severity required for children to be eligible for SSI benefits (GAO 1994, 1995).

In 1996, as part of welfare reform, Congress modified the definition of disability for children. Legislators replaced the comparable severity (to adults) criteria with a definition of disability that is unique to children. Under the new definition, a child's impairment—or combination of impairments—is considered disabling only if it results in marked and severe functional limitations, is expected to result in death, or has lasted or can be expected to last at least twelve months. The new focus on assessing the severity of impairments among children was reflected in changes in the evaluation process. The legislation removed the IFA, replacing it with criteria based on functional equivalence or evaluations of the extent to which impairments meet or exceed medical-listing-level severity. In practice these changes meant that although functional limitations continued to include behavior-related limitations, they no longer covered the same breadth of functioning included in the IFA. For example, Congress specifically removed maladaptive-behavior disorder from the functional-listing criteria. Thus, the post-1996 standard represents a broader measure of disability than originally applied to children but a narrower standard than the one used between 1990 and 1996.

**Applying Changing Rules.** Figure 1 clearly shows that changes in rules for children applying for SSI had a noticeable effect on caseloads, but the way SSI administrators interpreted these rules also had an impact on the rolls. The outcome of applying more subjective criteria to determine eligibility can be seen in the percentage of SSI-disabled children awards by two conditions: mental retardation and other mental conditions. These conditions represent extremes of the distribution between medically measurable and more subjectively determined. Mental retardation is a longstanding diagnosis with objective measurable criteria that can be applied consistently across evaluators. Mental impairments other than mental retardation are more difficult to measure objectively.

In 1983, approximately 37 percent of new beneficiaries qualified based on mental retardation and only 5 percent had other mental conditions. By 2003, over one-half of all new beneficiaries listed other mental conditions as their qualifying diagnosis and that grew to over 55 percent in 2009.

Part of the explanation for this increase is a specific change in the eligibility criteria—an SSA-based easing of criteria for meeting or exceeding the medical listings for mental impairments and a *Zebley*-based expansion to include functional limitations. But following this change in criteria, the share of new beneficiaries based on a mental condition has continued to grow at a rate much closer to the rapid rate that immediately followed the *Zebley* decision. The increase in the share of new beneficiaries with other

mental conditions since *Zebley*, and especially since the efforts to limit entry in 1996, suggests that gatekeeper discretion in determining these outcomes is another driver of SSI-disabled children caseload growth. This influence can be seen in the rise in awards based on functional criteria. The percentage of SSI-disabled children awards based on meeting or equaling the medical listings has declined substantially, and the percentage of children awarded benefits based on functional listings has risen accordingly.

These figures show that changes in program rules (especially the *Zebley* decision), and the subsequent administration of these rules, are affecting the patterns of program growth in figure 1. Hence, the growth in the SSI-disabled children rolls does not seem consistent with changes in the underlying health conditions among children. Rather, it appears to be based on increases in applications and acceptances onto the rolls that revolve around program eligibility rules and their implementation.

In sum, the research findings above provide plausible evidence that SSI-disabled children program growth has primarily been driven by factors other than the declining health of poor children. Loosening of program rules in the wake of the *Zebley* case has made it more difficult for gatekeepers to judge eligibility and welfare reform has increasingly made it in the interest of poor single mothers who have children with some impairments to apply for the more lucrative SSI-disabled children benefits often with the assistance of states attempting to reduce their TANF costs.

### **Unintended Consequences and Long-Term Costs**

We have argued above that the rise in SSI-disabled children caseloads and costs are primary policy driven. Some would agree with us that this is the case but that while it is costly to provide benefits to the poor via this program, these funds none the less provide additional resources to a poor population. While that is certainly the case, we argue that the current program has one addition unintended consequence that makes it a much less than ideal program for integrating poor children with disabilities in the mainstream society as they age out of the program and hence made be detrimental to the long term interests of these children. Hemmeter, Kauff, and Wittenburg (2009) find that nearly two-thirds of these children transition directly to the SSI-adult disability rolls. Once this transition is complete, very few attempt to work thereafter. Moreover, of those who do not move directly onto the rolls, only about 60 percent are employed at age nineteen (Hemmeter, Kauff, and Wittenburg 2009). Thus, most SSI-disabled children beneficiaries age out of this program into what is likely to be a permanent life on the SSI-disabled adults program or, in the event of denial of SSI-disabled adult benefits, turn to other forms of social welfare. This outcome is costly both to the beneficiaries who live their lives at or near the poverty threshold and to taxpayers who are funding the benefits.

### **The Case for Fundamental Change**

The SSI-disabled children program closely resembles general welfare programs in the United States and, thus, can be changed using many of the same principles applied in moving from AFDC to TANF. This would mean moving jurisdiction of the SSI-disabled

children programs from the SSA to the states. Unlike the previous periods when SSI-like programs were in state hands, this devolution would, like TANF, hold states accountable to federal guidelines regarding outcomes of people with disabilities. Like TANF, the SSI-disabled children program could be funded by block grants from the federal government, and states could be asked to comply with broad goals. At the same time, states would be allowed and encouraged to innovate and create work based alternatives to long-term cash support for applicants with disabilities.

Following welfare reform, and in keeping with the changing views about the integration of children with disabilities into the schools, we urge that families of children in the SSI-disabled children program be placed under the case management of state welfare agencies and that states use the same mix of supports (for example, child care and job training) and requirements (such as potential loss of benefits for noncooperation) to encourage working-age adults in these families to work. States would be able to use their funds to better target the special needs of the children with disabilities in these families. States would also be able to use these funds to provide services, rather than cash, to children with disabilities directly. These services could be refined to match the specific needs of the local population and, ideally, to improve the long-run ability of these children to enter the labor force.

These types of changes would move toward solving a number of problems with the current program. First, on equity grounds, placing responsibility for all welfare families with the states would reduce the difference in treatment of poor families based on whether they have children who meet the SSI-disabled children standards. Second, devolving the SSI-disabled children program to the states would limit states' incentives to shift the costs of managing welfare caseloads to the federal government through the SSI system. Finally, because states would carry the full burden of children with disabilities who remained in their welfare population once they reached working age, they would have a much greater incentive to provide the education, training, and accommodation necessary to enable children with disabilities to enter the workforce as adults.

**Can States Manage the SSI-disabled Children Program?** State welfare agencies now have over a decade of experience in moving welfare mothers and other welfare clients into the workforce. Although this would be a significant change from the last thirty years, and one that states may not want to undertake in a time of severe budget pressures, we argue that it makes sense to integrate the SSI-disabled children population into the broader state-run social safety net for low income residents. Providing states with block grants to use for all of their low-income populations has the potential to generate more experimentation and work-oriented programs, including rehabilitation, job training, and accommodation efforts focused on individuals with disabilities. If augmented by the same federal commitments given to low-income single mothers, such as the EITC, child tax credits, and health insurance, states will likely be willing and efficient managers.



## References

Garrett, Alma. B., and Sherry H. Glied. 2000. Does State AFDC Generosity Affect Child SSI Participation? *Journal of Policy Analysis and Management* 19 (2): 275–95.

Government Accountability Office (GAO). 1994. *Rapid Rise in Children on SSI Disability Rolls Follows New Regulations*. Washington, DC.

Government Accountability Office (GAO). 1995. *New Functional Assessments for Children Raise Eligibility Questions*. Washington, DC.

Hemmeter, Jeffrey, Jacqueline Kauff, and David C. Wittenburg. 2009. Changing Circumstances: Experiences of Child SSI Recipients before and after Their Age-18 Redetermination for Adult Benefits. *Journal of Vocation Rehabilitation* 30 (3): 201–21.

Kubik, Jeffrey D. 1999. Incentives for the Identification and Treatment of Children with Disabilities: The Supplemental Security Income Program. *Journal of Public Economics* 73: 187–215.

Loprest, Pamela, and David Wittenburg. 2007. Post-Transition Experiences of Former Child SSI Recipients. *Social Service Review* 81 (4): 583–608.

Rupp, Kalman, and Steven Ressler. 2009. Family Caregiving and Employment among Parents of Children with Disabilities on SSI. *Journal of Vocational Rehabilitation* 30 (3): 153–75.

Social Security Administration. 2009a. *Annual Report of the Supplemental Security Income Program*. Washington, DC.

Wiseman, Michael. 2010. *Supplemental Security Income for the Second Decade. Prepared for conference: Reducing Poverty and Economic Distress after ARRA; The Most Promising Approaches*. Washington, DC: Urban Institute.